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Prospective Payment For Hospitals Under Medicare

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With health care costs running far ahead of over-all inflation, the Administration and the Congress have acted to bring those costs into line with the Nation's economy On April 22, the President signed the Social Security Amendments of 1983 into law. One major provision requires activation of the Administration-proposed Prospective Payment System for most hospitals certified to provide care under the Medicare program for the elderly

October 1, 1983 implementation of the provision by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services will be completed in annual stages by October 1, 1986.

- Prospective Payment will change the way hospitals provide Medicare treatment
- Its impact will be profound
- Medicare beneficiaries will benefit from the change.
- Efficient hospitals will benefit from the change.
- Inefficient hospitals will have to change their ways in order to keep pace with this new payment system.

Why does the Nation need a new system of Medicare payment for hospitals? Foremost among the reasons: The Nation cannot afford the old system any more.

REASON FOR CHANGE: Rapid Cost Increases

In 1965 health care accounted for 6 percent of the gross national product. In 1982 it hit 10.5 percent, increasing annually in the intervening 17 years, and it still has not leveled off. In 1982, health care cost an estimated $322 billion, nearly 12.5 percent higher than the previous year Approximately 27 percent of that total was paid by Medicare and Medicaid (Federal-State program for the needy).

With the 1965 enactment of Medicare and Medicaid, total Federal health care outlays in that first year were $3.6 billion. By 1982 they had soared to $83.7 billion. Medicare and Medicaid funds accounted for $67.8 billion of that total. Today, government is the single largest payer of the Nation's health care costs.

In the Medicare program alone, spending for hospital care accounted for approximately two-thirds of the $50.9 billion expended on Part A (hospital) and Part B (medical) benefits in 1982 At the same time, physician and supplier services (medical) accounted for approximately one-fourth of the total outlay. Outpatient care, home health services and skilled nursing facilities accounted for the remaining 9 percent of Medicare dollars.

In 1982, hospital costs increased 12.6 percent, three times the general rate of inflation. This rapid inflation had a dramatic effect on Medicare spending Medicare hospital expenditures are more than $3 billion a month, where they once were $3 billion for an entire year.

High costs also impacted directly on the 29 4 million Medicare beneficiaries since the deductibles they must pay automatically increase proportional to cost increases. They have risen at an average of 17.5 percent annually since 1979.

PROSPECTIVE PAYMENT: What it is; How it works

A significant reason for the excessive increases in hospital costs has been the cost-based system of reimbursement. Since that system paid hospitals after the fact based on costs, it provided a convenient pass-through to third-party payers, whether government or a private insurer. It also had no incentives to control costs, no rewards for efficiency, and a costly regulatory process to monitor the entire system.

In 1982, the Department of Health and Human Services directed HCFA to develop a Medicare prospective payment system that met these goals:

- No Additional Billing of Beneficiaries by Hospitals Beyond the Normal Deductible and Copayment Amounts
- Maintain Beneficiary Access to Quality Care
- Reduce Cost Reporting Burdens
- Incentives for Efficiency
- No Increase in Expenditures
- Pay as Prudent Buyer
- Predictable Impact
- Implement Quickly
- Easy to Administer
- Easier to understand for beneficiaries
- Better basis for hospital budgeting

The Prospective Payment System is based on a unit of payment—the pre-set rate per case or type of discharge. The new system categorizes discharges by a method known as Diagnosis Related Group Classifications, or DRGs, based on:

- patient diagnosis
- patient age and sex
- treatment procedure
- discharge status

(Yale University's Center for Health Studies, under contract with HCFA, developed 467 DRGs over a ten-year period by using statistical and clinical analysis group diagnoses on the basis of patient characteristics and treatment procedures.)

There will be regional, rural and urban, and wage adjustments to the rates for DRGs. There will be a pass-through of hospital capital costs for the first few years of the program and for certain medical education costs. The rates will be updated annually. Most important: there will be rewards for efficiency. Hospitals will be paid the pre-set rate even if they can provide the service at a lower cost than the rate. Special reimbursement may be added for extraordinarily long or expensive care.

Implementation of prospective payment system begins in the fiscal year beginning October 1, 1983, when 75 percent of the reimbursement to hospitals will be based on the specific hospitals own historical cost experience. The remaining 25 percent is based on the regional DRG rate. The following year, the proportions shift to 50 percent hospital-specific rate, and 50 percent as a combination of national and regional DRG rates.

In the third year, only 25 percent is hospital-specific and 75 percent is national and regional DRG-based. In the fiscal year beginning October 1, 1986, a completely national DRG rate of reimbursement will be in force, adjusted according to urban or rural settings and wage levels in each area.

Hospital direct medical education expenses will continue to be paid on a reasonable cost basis.

WHAT HOSPITALS PARTICIPATE IN THE NEW SYSTEM?

All hospitals participating in Medicare are covered by the new system of reimbursement except psychiatric hospitals, long-term care hospitals, children's hospitals, hospitals in Puerto Rico and the Federal Territories, rehabilitation hospitals and a few other special cases There is additional consideration for hospitals that are sole community providers. They will be entitled to an adjustment—if volume decreases—to compensate for fixed costs and reasonable costs of maintaining core staff and services Their payment will also remain over time at the initial transition year rate of seventy-five/twenty-five.

WHAT THIS NEW SYSTEM MEANS TO HOSPITALS:

If a hospital's costs for providing Medicare services exceed the DRG rate (the prospective payment level) the hospital will lose money. If a hospital provides that same service at a lower cost than the rate, it will make a profit The incentive is to find areas for savings in order to avoid losses. The old cost-based incentive was simply to increase revenues by increasing costs.

Note:

The 1983 law setting up prospective payment also permits States to set up their own cost control systems, although cost to the Medicare program can be no greater than would have been paid under the national prospective payment system. If States meet certain conditions, hospitals can be reimbursed under their systems for Medicare services. The State systems do not have to be based on DRGs.

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WHAT THE NEW SYSTEM MEANS TO BENEFICIARIES

Will Medicare prospective payment cause hospitals to cut costs by cutting services that should not be cut? The answer is no, based on a series of research studies and demonstration projects which began as early as 1974 for the Department of Health and Human Services that looked at this very question. Actually, unnecessary services were reduced and providers of Medicare services were discouraged from performing certain highly technical surgical procedures unless they had the volume that was required for proficiency

- To ensure that quality care is safeguarded, the Department is extending its system of admission pattern monitoring to identify unusual changes in the volume of admissions, case-mix, total reimbursement and discharge status. All changes will be investigated. In addition, the Department is setting up verifications to assure that DRGs are correct and not creeping into costlier classifications. Meanwhile, hospitals must contract with Peer Review Organizations (PROs), as of Oct 1, 1984, if they are to be paid under the prospective system. The PROs will review diagnoses, quality of care provided, the appropriateness of admissions and discharges, and the nature and handling of unusual cases.

- The 1983 law also provides for review of the prospective payment system by the Congressional Office of Technology Assessment, which will appoint a 15-member expert commission consisting of physicians, nurses, hospital managers, representatives of business groups and others They will advise the Congress and the Secretary on prospective payment progress and issues. By 1986 and at least every four years after that, they will advise on whether the rate increases built into the system are adequate Finally, they will examine coverage issues and technical issues concerning the DRG system.

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